Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 01/12/01 to 02/14/01?

   b. The request was received on 01/10/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/28/02
   b. HCFA 1450's
   c. EOB
   d. EOBs from other carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution dated 02/27/02
   b. HCFA 1450's
   c. Audit summaries/EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 02/14/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 02/14/02. The response from the insurance carrier was received in the Division on 02/27/02. Therefore, the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   The requestor states in the correspondence dated 02/28/02 that…"The Carrier has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges, and group carriers are allowing 100% of our billed charges. Enclosed are examples of bills for the same/similar type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid." The Provider is seeking additional reimbursement in the amount of $2,391.25 for the dates of service 01/12/01 to 02/14/01.

2. Respondent:

   Respondent has denied the disputed charges as "705 - ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 01/12/01 and extending through 02/14/01.

2. The Provider billed the Carrier $2,521.39 for the dates of service 01/12/01 to 02/14/01.

3. The Carrier paid $1,130.14 for disputed dates of service 01/12/01 to 02/14/01.

4. The Provider is seeking additional payment in the amount of $1,391.25.

5. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted additional reimbursement data (EOBs from various carriers) for similar services to patients of an equivalent standard of living in their geographical area. This information does comply with the criteria of Sec 413.011 (d) of the Workers Compensation Act.

However, the carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted a copy of Carrier's payment methodology. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. Develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Labor Code §413.011 and §§133.1 and 134.1 of this title;"

Per Exhibit I, Carrier's methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. Carrier averaged the payments in each level for the 6 states and designated this as the base fee for each intensity level. Carrier also takes into account local economic factors and applies HCFA's wage index factor to the base fees. If the specific area is not addressed in the wage index, Kemper uses the state average. Any extraordinary supply costs and lab tests are reimbursed as well, above and beyond the base fee and wage index. Carrier sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers' compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing.

The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences.

Exhibit 2 provides a list of Texas ASC centers (bills processed in May and June 2000) who have been paid based on Carrier's methodology. In Exhibit 3, Carrier indicates that it has canvassed other payers in the system who reimburse on the average of 110% to 140% of Medicare allowable rates and even though Carrier does not use Medicare, it compares favorably because it pays an average of 150% of Medicare.

As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Even though the provider has submitted EOB's demonstrating what they have been reimbursed by other carrier's (usual and customary), they have not provided information to show what other ASC's are being paid for the same or similar services nor what the other carriers' methodologies consist of to determine fair and reasonable reimbursement. Carrier has provided their methodology which conforms with the additional criteria of Sec. 413.011 (b), "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical care cost control." It also complies with Rule 133.304 (i). Therefore, **no** further reimbursement is recommended.

The above Findings and Decision are hereby issued this 15th day of April 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.